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The Hampden Hippocrat

Jan.—Feb.
1990

Noble Hospital

Westfield, Massachusetts

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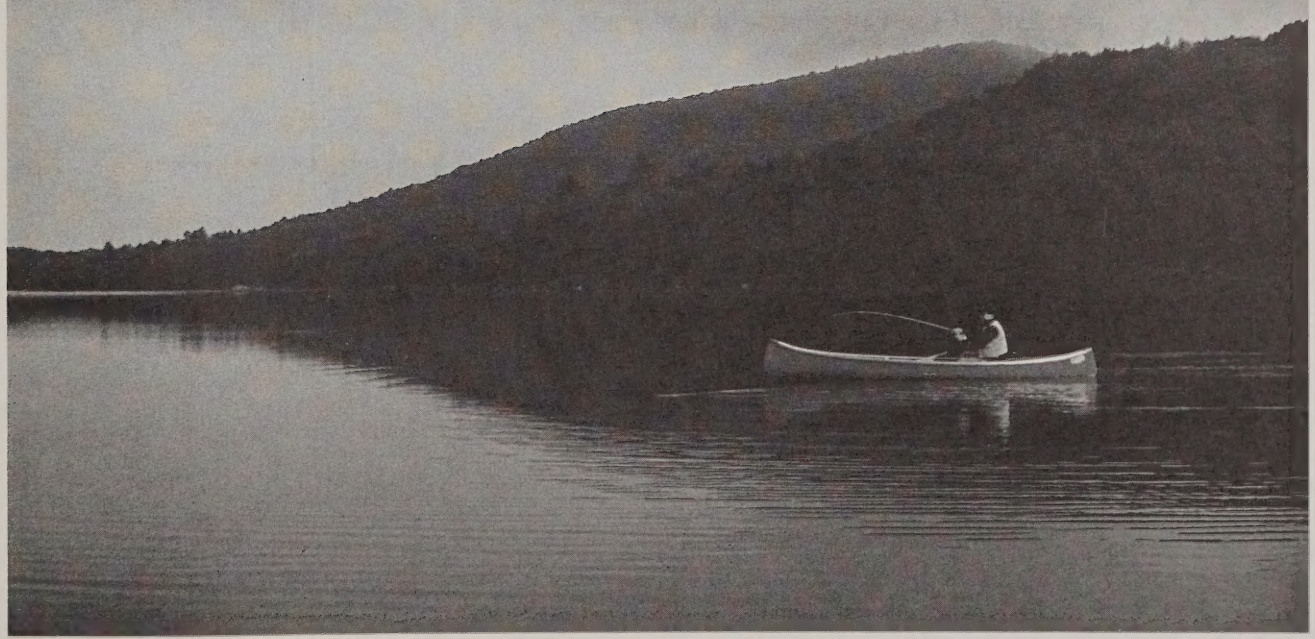

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HAMPDEN DISTRICT MEDICAL SOCIETY 1989-1990 SEASON

DISTRICT MEETING

PLACE:	**SHERATON WEST** West Springfield, MA
DATE:	Tuesday, January 23, 1990
BUSINESS MEETING:	6:00 p.m.
SOCIAL HOUR:	7:00 p.m.
DINNER:	7:30 p.m., Spouses are welcome!
SPEAKER:	C. JOHN TUPPER, M.D., President-Elect American Medical Association
SUBJECT:	Major Medical Issue Update

NOTE: If you must cancel your dinner reservation, please call the office before noon on January 23rd. If the cancellation is not made, you will be BILLED for your dinner.

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THE HAMPDEN HIPPOCRAT

JANUARY-FEBRUARY 1990
VOLUME XXXXV NO. 6

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On our cover is Noble Hospital in Westfield, Massachusetts. See related article on page 6 in this issue.

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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Noble Hospital

This is the sixth in a continuing series of articles featuring Western Massachusetts Hospitals

In the past decade, Noble Hospital has effectively met the health care challenges presented by our changing industry. As a 128 bed community hospital serving greater Westfield, its goal is to provide quality health services to its community - making travel outside of greater Westfield unnecessary for most health care services.

The hospital's 1988 affiliation with Providence Systems has strengthened Noble's position in the community through cooperation with other institutions. By streamlining operations, Noble has succeeded in achieving growth and advancement in the face of a hostile health care environment.

Pursuing and implementing realistic strategic plans have resulted in a solid history of meeting the basic health care needs of the greater Westfield community. The hospital's most recent achievement in its mission to provide such care is the new Bronson Rehabilitation Unit - a 15-bed inpatient rehabilitation unit for stroke and accident victims. Rehabilitation patients at Noble Hospital benefit significantly from being close to home, where family and friends can provide constant help and encouragement. Family members have the reassurance of knowing the patient is receiving the rehabilitative care they need close to home, making visits during the 30 day stay as convenient as possible.

Dr. Joseph P. Keenan
President, Hospital Medical Staff

A new location for the Same Day Care Unit has resulted in a more streamlined approach to one day medical and surgical procedures at Noble Hospital. All medical procedures, including laser eye surgery, urological procedures, gastro-intestinal endoscopies, chemotherapy and transfusions, are performed in diagnostic examination rooms on the unit. Patient recovery areas are bright and comfortable.

Noble also boasts a highly advanced Intensive and Coronary Care Unit. The six-bed unit features break-away doors and glass walls to each bed, situated around a central nursing station. Other cardiac care capabilities include such high technology resources as the echocardiogram, carotid duplex scan, and nuclear medicine computer for heart stress testing.

Phase IV will soon be added to the Cardiac Rehabilitaion Program. In an effort to make the program convenient and provide patients with a setting where they may continue their cardiovascular exercise maintenance program, the Phase IV program will be held at both the hospital and at the Westfield YMCA.

Recent additions in continuing the hospital's commitment to advanced technology include two ophthalmology lasers, an argon and a YAG, and a surgical KPT (three in one) laser applicable to a variety of surgeries, including ENT, gynecological, urological, and plastic surgeries.

Noble has entered into a joint agreement with four other Western Massachusetts hospitals to bring magnetic resonance imaging (MRI) to Westfield. The agreement allows Noble to provide patients with the most technologically up to date imaging technique. Because of specific space needs and limited space in the existing hospital building, an addition will be built to house the mobile MRI equipment. A mobile pad as well as reception, changing and working areas and office space will be built just outside the Emergency Room entrance.

For nearly a decade, a 20-bed inpatient psychiatric unit has been helping people from all over Western Massachusetts to cope with emotional disorders. The Fowler Wing has an established and tested presence in the mental health community. In its eight years of existence, it has earned a regional reputation for excellence.

The Fowler Wing looks forward to having electroconvulsive therapy (ECT) equipment available in the near future. Over the past decade, ECT has been gaining widespread recognition as a valuable therapy for specific types of psychiatric disorders. Noble Hospital will become one of the few hospitals in the area with ECT capabilities.

Two years ago, another health care need was recognized and addressed with the creation of a new service. With shorter hospital stays and and older patient population, the need for home care services in the greater Westfield area became apparent. Westhills Home Health Care, Inc., was created in 1986 and became certified to receive Medicare and Medicaid insured patients in 1987. Plans are now underway to accept private pay patients.

Entering its second year of serving the health care needs of local business and industry is Noble's Occupational Health program. The program includes educational courses, such as first aid, wellness programs like cholesterol and hypertension screenings, and pre-employment physicals. The Occupational Health coordinator also serves as liaison between local industry and Noble's Emergency Department concerning worker compensation cases.

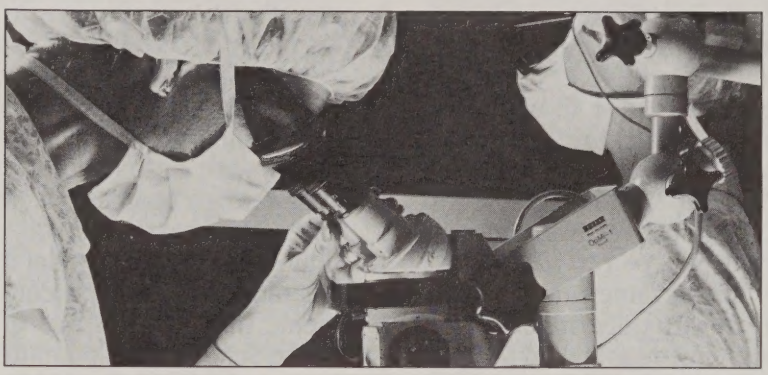
Noble's medical Laboratory was granted renewal of accreditation by the College of American Pathologists (CAP) in the spring of 1989. First accredited more than ten years ago, Noble Hospital's Laboratory was the first in the area to achieve recognition of its high quality and excellence. A fully automated chemistry analyzer and remote reporting capabilities in doctor's offices minimize turn-around time for test results. For the convenience of both patients and physicians, Noble operates two satellite laboratories in Westfield, complete with computerized reporting.

In the ever-changing role of health-care provider, Noble recognizes the need to provide services to prevent illness as well as to treat it. Through a myriad of educational opportunities, Noble strives to help community residents live healthier lifestyles. Education courses include CPR, first aid, weight loss, and smoking cessation. Seminars, health fairs, and screenings promote healthy lifestyles as well as hospital services. A variety of physician and nursing continuing education programs are provided requlary.

Noble Hospital continues its aggressive recruitment of medical staff members. In the summer of 1988, a new wing was added to house the office of new obstetrician/gynecologist, Robert Wool, M.D. The hospital is currently recruiting additional OB/GYN's to join Dr. Wool.

Physicians have recently joined the staff in the fields of anesthesiology, otolaryngology, cardiology and internal medicine. These physicians have reflected the dedication to community and personal care that characterize Noble.

While Noble has had many successes in recruiting physicians to the community, the trustees, medical staff and management all recognize the need and room for additional physicians, especially in the area of primary care. Currently, the hospital administration is working closely with the medical staff to create an environment attractive both to existing Westfield physicians and prospective physicians.



Wearing protective clothing and glasses, operating room nurses prepare the laser for use.

In response to proposed state budget cuts to the child immunization program administered by local health departments, the Medical Staff of Noble Hospital has donated $1000 to the Westfield Department of Public Health. The funds are to be used to purchase immunization specifically for children.

State budget cutbacks have threatened to trim $1.3 million from the program which provides free immunizations to children statewide. The immunization program, which cost $12 million a year, has been successful in curbing outbreaks of childhood diseases.

The Noble Hospital Medical Staff is the first medical staff in the Western Massachusetts area to contribute funds to this much needed and valuable program. The members of the Medical Staff were concerned that, without the free immunization program, outbreaks of such illnesses as measles and rubella could become more widespread.

As a community hospital, Noble is proud of its successes in providing comprehensive health services to its community. With state of the art equipment, trained technologists and health care professionals, and a dedicated medical staff, Noble provides the highest quality of care to its patients. Rooted in the tradition of serving the community, Noble maintains a home-town atmosphere with the personal attention patients want and the quality care they need. ■

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Committee Highlights

The Executive Committee of HDMS met on October 17, 1989. The evening began with a brief update on Hippocrat Advertising and was followed by the introduction of Ms. Kerin Milesky, the coordinator of the new Central Regional office of the Mass. Medical Society whose office just opened on October 2, 1989. (Please see report from Ms. Milesky elsewhere in this issue.)

Ms. Michael Barnes was present to give an update on the Public Relations Program. Ms. Barnes said that public service spots on timely topics are being planned to be shown on Channel 40 and Channel 22. She is also working with Channel 40 on a 30 minute medical program with audience participation. It is hoped to have WNNZ Radio pick up this program at the same time for relay over the radio. A position drive with gubernatorial candidates is being planned. These meetings should be open discussion with the candidates asking them their opinions on health care issues and then publishing the discussion in the Hampden Hippocrat. A Speakers Bureau will also be planned.

There was subsequent discussion of the search for new office space for the Medical Society and it was announced that a space on St. James Avenue and Carew Street was being looked at.

Dr. Keenan then noted that there had been reports from Drs. Terry Ryan and Nicholas Coe that they would be leaving the Hippocrat as co-editors come April, 1990. A search for other co-editors to work with Drs. Gulab Shah and Donald Higby will begin.

Dr. Shah stated that he has drawn up a memo of understanding with Barnes and Barnes Advertising and the Hampden Hippocrat and that the Hampden Hippocrat finances would be handled on an issue by issue basis.

Dr. Cahill reported that another physician has decided to settle with the Attorney General's Office, further depleting the number of the Springfield 24. Dr. Cahill stated that they expect the case will go before a judge in May, 1990.

Dr. Kenan reported that the Medical Staff of Noble Hospital has voted to send a check in the amount of $1,000.00 to the Westfield Health Department to help them purchase vaccines for immunizations. A motion was then made and seconded and passed unanimously that the Executive Committee of HDMS approve a loan of $2,500.00 to the newly established Hampden Vaccine Fund. Letters were to be sent to the eight area hospitals' medical staffs asking them for contributions.

The November 21, 1989, of the Executive Committee began with the discussion as to who might be interested in working as editors of the Hampden Hippocrat. Several names were discussed but there were no firm applicants.

Under new business the featured subjects were an update on the search for office space was given. Work continues on this, but no final decision has been made. Consideration to development of an ad hoc committee to tackle this problem was given.

The Scholarship Committee reported that six students had received scholarships in the amount of $1,100.00 and four students had received Millman Foundation Scholarship Loans of $1,000.00 each.

It was noted that there will be a meeting at Mass. Medical Society on December 13, 1989, to discuss the combining of district societies. At least some of the officers of the HDMS will attend.

A Hampden Vaccine Fund press conference was held under the direction of Michael Barnes on November 7, 1989, and was reported to be very successful. Dr. Keenan made the announcement and it was carried in the morning Union News. Drs. Walter Pacosa, Elizabeth Savich and Paul Taylor also worked with media on T.V. coverage and interviews on the vaccine shortage.

There was a report of the financial problems encountered by the Central High School Clinic. This report was referred to Dr. Riley, Chairman of the Public Health Committee.

Ms. Milesky reported that a practice management series was being planned for Western Massachusetts by Mass. Medical Society next spring.

Dr. Weiss reported that the Nomination Committee of the Mass. Medical Society was seeking names for candidates for the Mass. Medical Society offices.

continued

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The Publications Committee met in November and welcomed its newest member, Dr. Brigid Glackin.

It was decided by the Public Relations Committee to change the month's editions of the Hippocrat from a December/January, February/March cycle to a January/February, March/April cycle beginning with the next issue.

The Public Health Committee met on Tuesday, October 3, 1989. Commissioner Cipolla outlined the events of the Health Department since the drastic budget cuts early this summer. Earlier hopes that the school's Dental Program could be continued by using retired dentists failed to materialize because of potential liability problems of the retired dentists who no longer carry liability insurance. On the positive side the Sexually Transmitted Disease Clinic has been funded by the state and some of the funding has even been increased. Federal funding has been given also for the Homeless Program and the Health Department will be working with the Open Pantry Food for the Homeless Program.

There was a discussion of the new Infectious Medical Waste Bill. The members of the Committee suggested there might be a way for the Society to hire a collection agency to pick up waste at physician's offices for a set fee. It was noted that the Baystate Medical Center was working on a similar program and it was thought that the Mass. Medical Society may also be involved.

It was noted that a new State Health Commissioner, Mr. David Mulligan, has been appointed to replace Dr. Prothrow-Stith who resigned recently.

The next Public Health Committee meeting was held on October 31, 1989. Ms. Kerin Milesky was present as an invited guest. Ms. Milesky reviewed the program set up by Mass. Medical Society with Medical Wast Management Company. This company will provide special containers for various types of office medical waste and remove the waste quarterly at a cost of $370.00 per year. MMS will receive some monies back when members sign up with this company. These monies will go to the MMS Scholarship Fund.

Commissioner Cipolla then reviewed the local program for drug and alcohol abuse which is known locally as the Community 2,000 Program. The Community 2,000 Program has applied for a two year $200,000.00 grant being offered by the Robert Wood Johnson Foundation to help coordinate all drug and alcohol programs. Springfield has been amongst a select group of finalists to be selected for review. Commissioner Cipolla said there were four areas to be considered in this grant:

1. Awareness
2. Systems Development
3. Early Detection and Intervention
4. Care and Treatment

At the time of publication we were unaware as to whether Springfield was successful in obtaining this grant or not. ■

Terry D. Ryan, M.D.
Co-Editor, Hampden Hippocrat

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Fifth Annual Medical Ethics Forum

Father Matthew Temple delivered the annual medical ethics lecture at Mercy Hospital on October 25th, 1989. In his discourse he considered several ethical questions raised by present and future genetic technology.

Father Temple is uniquely qualified in that he is a Catholic priest of the Carmelite order, holds an M.A. in theology from Catholic University, and holds a Ph.D. in biology from Georgetown University, where he was the director of the cytogenetics laboratory at Georgetown University Hospital. He is now Professor of Biology at Nazareth College in Rochester, N.Y. He has published several major articles and book chapters, and is widely regarded as an expert in cytogenetics and medical ethics.

Genetics is a science which deals with both mortality and immortality, since the major limitations in our lives are related to our heredity, whereas that part of us which will persist in the world has to do with the genes we pass on, he said.

Ethics, on the other hand, is the science which discovers what we ought to do and what we ought not to do.

Finally, medicine is the art of diagnosing, treating, and preventing disease.

In order to diagnose, it is necessary to have an accurate description of what is normal. In genetic science we do not yet understand the "range of normal."

Given the above, Dr. Temple discussed several areas of genetic diagnosis and therapy.

With respect to prenatal diagnosis by amniocentesis or chorionic villus sampling, one question deals with who the patient is. The fetus does not request the diagnositc step, and may in fact not be ill at all, and yet has to undergo the risk, including the risk of death, associated with the procedure. Furthermore, even though we can diagnose, we seldom can treat the fetus; and even when we diagnose some genetic disorders, we cannot accurately "prognose". The diagnosis of Down's syndrome does not predict the ultimate potential of the fetus, and Down's patients have written books and gone to college.

Father Temple feels that both the mother and the fetus should be regarded as "patients" with respect to prenatal diagnosis, and the rights of each need to be considered. He pointed out that the Roman Catholic position is that the fetus is a human person as a matter of genetics and a matter of faith, and cannot ethically be regarded as "dispensible", since the most fundamental right is the right to life. But he also stressed that there must be compassion for couples who face very difficult ethical decisions following the discovery of a genetic defect in the fetus, and that any ethical health care institution must have competent ethical and moral counseling available.

Molecular genetics increases our ability to make genetic diagnoses, and opens up possibilities for therapy.

In cystic fibrosis, a disease that affects one in two thousand newborns in this country, and which mortally affects respiratory and gastrointestinal function because of a defect in epithelial transport of chloride, a missing set of nucleotides is responsible, and can now be detected in 70% of patients. Though no treatment is currently possible, the hope for treatment lies in molecular genetics. Even now, early detection offers the possibility of initiation of prophylaxis before clinical symptoms occur, which may be helpful in the long run.

Although Father Temple is generally positive about molecular genetics as a diagnostic and therapeutic tool, he pointed out that the history of the use of genetic knowledge is not praiseworthy. The ability to diagnose sickle cell trait led to stigmatization of such patient by insurors and employers even though the patients were asymptomatic. Similarly, the ability to make genetic diagnoses with mail-order tests and kits for home use is worrisome, since acting on these results intelligently requires much more knowledge.

Gene therapy is an area which is still largely theoretical. It can be defined as the use of molecular knowledge to replace, correct, or compensate for dysfunctional or missing genes.

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Although this area in general may sound like a "brave new world", it is ethically not different from surgery. The use of a virus as a vector to alter genetic material is not fundamentally different from the use of a scalpel to alter the anatomy of a patient. The ethical questions relate in this situation to the likelihood of the vector causing unexpected disease in the patient or his/her contacts, and even that seems quite preventable by building "incomplete" viruses.

Genetic therapy must therefore by analyzed in terms of risks and benefits, to patient and to society.

Specific Roman Catholic concerns about the world of genetic medicine can be summed up as follows:

1. Catholic theology not only regards genetic diagnosis and therapy as intrinsically unobjectionable, but in fact sees it as desirable, since it follows God's design that man be "King" of nature—that is, control nature for his benefit. But the fundamental issues revolve around the promotion of health and the respect of the rights of those involved.

2. In Catholic thought, there is an option to the poor; that is, Catholic ethics is not satisfied with fairness, but requires a bias towards those who are in need. This suggests that genetic technology should not be developed at the expense of providing adequately for the needs of the poor; and on the positive side, suggests that genetic medicine serves the poor, eg, the parents of a child with a genetic disorder, the patient with such a disorder, and the embryo.

3. Genetic medicine must respect the rights of the embryo; For example, a theoretical approach to the cure of sickle cell anemia might be to use in vitro fertilization to develop embryos, and then use a viral vector to correct the sickle cell gene. This approach would violate a Catholic guideline in that in vitro fertilization is seen as the denial of the right of the child to be conceived in an act of human love. (However, there is movement in the Church to re-examine in-vitro fertilization, since many feel that this can be considered a loving act). More importantly, this approach would also be illicit if the risk of death was high (eg, multiple embryos formed and only one being implanted).

Dr. Temple concluded by remarking that an experienced surgeon should sit on ethical boards that examine this new science as it applies to medicine, since surgeons were in the habit of making these kinds of decisions every day.

Dr. Solvaang Pfluger, Chief of Cytogenetics at Baystate Medical Center, commented that some of the issues which face diagnostic cytogenetics today have to do with what is normal. Should a daughter be considered abnormal if you want a son? Soon we will be able to predict physical beauty, intelligence quotient, and eye color from genetic technology. Even now, increasing numbers of parents are making decisions to abort on the basis of the sex of the offspring. Those involved in diagnostic cytogenetics are constantly being confronted with very disturbing choices. ■

Donald J. Higby, M.D.
Co-Editor, Hampden Hippocrat

A complete video-tape of the Fifth Annual H.D.M.S. Medical Ethics Forum is available from Mrs. Nystrom at H.D.M.S. Office.

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How can physician best manage his investments?

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Q) I am a 34-year-old self-employed physician. I am married and have three small children. My pension fund is fully funded with $225,000. This is currently invested in a variety of things including several mutual funds, CDs, bank stocks and insurance as well as cash.

I have about $50,000 per year of investable income, and herein lies my problem. I am not equipped either with time or the know-how to deal with this amount of money. Thus far, the investment advice that I have received has revolved too much around whatever it is that the advisor has to sell.

I would like to be very conservative without being stupid. Your suggestions and help would be appreciated.—J.R., Phoenix.

A) Doctors are probably the most oversolicited group in America when it comes to investment "opportunities," and I am sure you have friends who will be "feeding". hard-earned income to defunct tax shelters for several years. So let me tell you that you can avoid all the time spent in hearing offers, explanations and pitches if you can devote about an hour every six months to your investments and can divide by a number like 4 or 5.

By making this small effort, you will be saving yourself the investment sales fees on $50,000 a year which could run anywhere from $1,000 (at 2 percent) to $4,000 (at 8 percent). Divide that by 2 and your two hours a year "managing" your own investments will be worth somewhere between $500 and $2,000 an hour, a rate that probably exceeds your current billing rate for medical services.

At the same time, you will be managing your investments to reduce volatility and provide a long-term return that is attractive relative to CDs, insurance funds, etc.

How is this accomplished?

By creating what Chicago-based newsletter publisher Gerry Perritt calls "The All Weather Portfolio." Perritt's idea, the subject of an earlier column, was to take a look at the composition of world wealth and then make a portfolio of its components. In some years stocks will rise, in others it will be international bonds, and in others the best holding will be cash. While some people say they can make the most profitable selections of assets to hold for any period, Perritt took the opposite approach; He assumed you couldn't predict.

Instead, he let fixed proportions for each asset do the changing. If stocks are supposed to be 25 percent of the portfolio but go up to 50 percent in a year, they will be more than 25 percent of the total protfolio at the end of the year. If you adjust the portfolio at the end of every six months or a year, you will automatically sell assets that are rising in price and buy assets that are relatively cheap.

Perritts' model portfolio has the following components: 15 percent in small company stock funds; 15 percent in large company stock funds; 15 percent in international stock funds; 10 percent in international bond funds; 20 percent in U.S. bond funds; 10 percent in gold funds; and 15 percent in money market funds.

When he "backtested" the performance of this fund over the last 20 years by constructing an imaginary portfolio and rebalancing its components once a year, he found that it produced a compound return of 11.8 percent. This is far superior to the 9.2 percent return of the Standard and Poors 500 over the same period or the 7.4 percent return of Treasury bills. The portfolio beat the S and P 500 in 11 of 20 years, and its worst performance was a positive return of 1.3 percent in 1974—the year the S and P 500 plunged by 26.5 percent.

When I compared the return of the portfolio to figures from Lipper Analytical Services for equity funds, I found that the All Weather Portfolio grew by 518 percent over the 15-year period ending December 1987 while the average equity fund provided a return of 344 percent.

Will the performance advantage be so great in the future? No one knows. But I'd say the odds favor it, and if the performance difference repeats the past, being able to do simple division once a year will be a way for you to have your investments outperform about 75 percent of all equity portfolio managers.

How, specifically, do you do this?

You invest in no-load mutual funds that specialize in each of the categories of investment and sit down once or twice a year to rebalance the portfolio. No crystal ball required.

Here is a list of the funds for each category:

All Weather Portfolio:

- ☐ Small Companies: Nicholas IL, 414-272-6133.
- ☐ Large Companies: Vanguard Index Trust, 800-662-SHIP.
- ☐ International Stocks: Vanguard World-Int'l, 800-662-SHIP.
- ☐ International Bonds; T. Rowe Price Int'l Bond, 800-638-5660.
- ☐ U.S. Govt. Bonds: 20th Century U.S. Gov't Sec, 800-345-2021.
- ☐ Gold: Lexington Gold Fund, 800-526-0057.
- ☐ Money market fund of choice.

If you'd like to follow Perritt's advice and analysis, you can subscribe to the Mutual Fund Letter for $115 a year. (312-750-9300).

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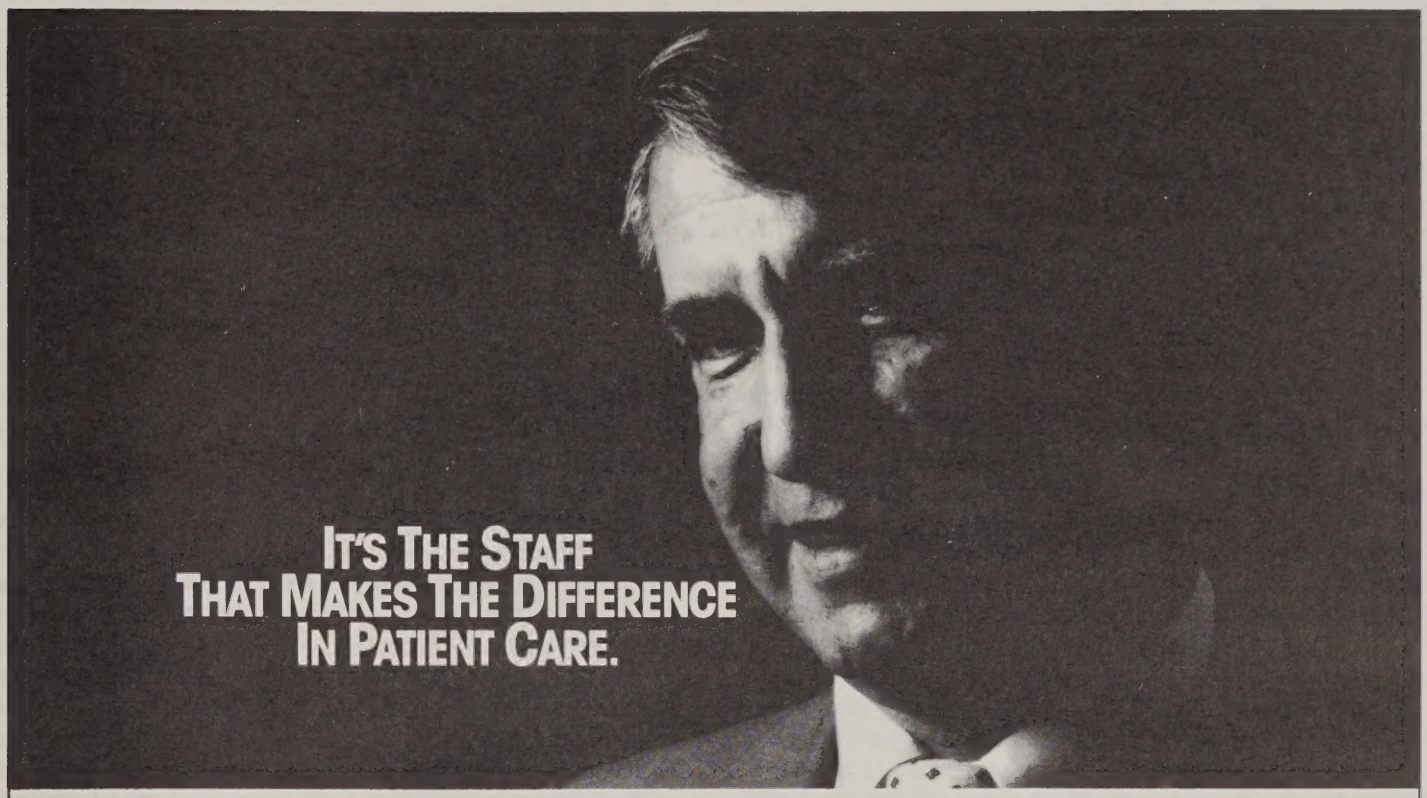

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Robert Hoffman, M.D.
Medical Director

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Medical Gamesmanship

When I was house officer my department chairman was a well known endocrinologist. His demeanor was always serious, and I don't recall that he ever smiled in my presence. Dr. F_____ in addition held office in the American College of Physicians, and was active in specialty politics as well. He was also quite aware of his uniqueness, and we house officers soon learned that an occassional word of admiration kept Dr. F_____ in a reasonably good frame of mind.

The old Firmin des Loges hospital was of architectural interest, I am sure. The basement, first, and second floors were laid out in a rough square, and contained the x-ray departments, offices, and lab space. But from there on up to the 26th floor, the hospital was constructed like a giant sail, with each patient floor about 200 feet long, but only about 30 feet wide. The medicine floors were grouped in a bank of four. Each morning, Dr. F_____ would make Chairman's rounds. The house officers and medical students assigned to the floor would assemble (depending on the floor) at precisely 8:15, 8:30, or 8:45, having completed work rounds. We would stand in front of the elevator. It was given that we be there, because our absence would be commented upon and sometimes would be the subject of the next day's Chairman's rounds, which was not considered good form.

The chairman, flanked by his chief resident and by the senior fellow in endocrinology, would step regally from the elevator, look us over slowly, and then turn towards the senior resident. "Show me an interesting patient!" During the entire fifteen minute visit, all communications between the Chairman and a member of the ward housestaff were conducted through the senior resident.

"Dr. B_____ will present the patient this morning," he would say.

Dr. F_____ would then fix Dr. B_____ in an emotionless stare, and say to the senior resident, "Have Dr. B_____ go ahead."

We soon learned that it was a waste of time to present an interesting heart patient to Dr. F_____. Electrocardiograms made his eyes glaze over, and like many Chairmen of Departments of medicine who were not cardiologists, he was no longer able to distinguish heart sounds from borborygmi, although of course the stethescope still protruded from the pocket of the white coat. On the other hand, problems related to endocrine disease or metabolic perturbations usually made him wax eloquent, and he would then demonstrate interesting physical findings, describe intricate physiology, and leave us with a feeling that we had really learned something.

Dr. K_____ was one of my senior residents during

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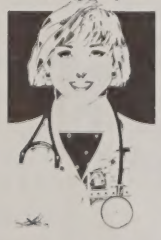

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my internship (PGY-1 to the modern generation). Unlike most senior residents, Dr. K_____ had interupted his post graduate training to spend four years in Vietnam, where he had learned a great deal of medicine but more importantly, had reached the point where he was not subject to intimidation. He was an excellent instructor provided that he could be kept on track, since he frequently digressed to an interesting anecdote about his Vietnam experience, many of which were not strictly medical, but had more to do with some of the ingenious ways young Vietnamese women used to separate American soldiers from their paychecks. Dr. K_____, probably because he had already had enough regimentation to last a lifetime, ran a rather laid-back service, and the bottom line was that each patient got seen and stupid mistakes were avoided. If we house officers adhered to those rules, we could pretty much run our own lives.

We could sense that Dr. K_____ was not impressed by the morning visits of Dr. F_____ and his entourage. Perhaps it was in the slouched posture, the sly grin, or the frequent glances at his watch. Dr. F_____ for some reason did not notice this mini-rebellion, perhaps because Dr. K_____ made the appropriate flattering noises.

A day came when a patient was admitted from clinic with myxedema. He was a textbook case, and we excitedly compared his signs and symptoms with the list in Harrison. Someone very quickly pointed out the patient would be an excellent case for Dr. F_____. Dr. K_____ thought a minute, then told us that we were not going to present the patient until he was completely worked up.

The next morning we presented the patient in the next bed—Dr. K_____ had insisted that we do so, despite there being several more interesting patients on the floor. The following day, he moved that patient out, and moved another in—and we presented that patient. This went on.

Each day Dr. F_____ would be led past our myxedematous patient and shown the patient in the next bed. On the second day, Dr. F_____ glanced at our "prize" but was quickly distracted. On the third day, Dr.F_____ stared a little longer. About the fifth day, he broke down and requested that we present the interesting patient in room 1417. Dr. K_____ told him that he had planned to do so, and proceded to present the new patient in the adjacent bed again.

Over the weekend Dr. K_____ started synthroid and sent the patient home. On Monday, when Dr. F_____ arrived, we made no mention of the fascinating patient with classical myxedema, and Dr. F_____ was obviously too proud to bring the issue up again. ■

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AIR FORCE

Letters to the Editor

October 3, 1989

Carol L. Nystrom, Executive Secretary
Hampden District Medical Society
1414 State Street
Springfield, MA 01190-2594

Dear Ms. Nystrom,

At a recent AMA practice seminar which I attended in Miami, county medical societies were recommended as special resources available to physicians searching for employment in their geographic area and would appreciate assistance which you can give us.

We currently reside in Miami because the National Public Health Service Corps assigned Dr. Cynthia Christoph to the South. She works as a general internist in a local indigent clinic as well as the AIDS coordinator for the clinic. All inpatient followup is her responsibility. Dr. James Greve is working as an attending physician at the University of Miami, Jackson Memorial Hospital in the department of Interventional Radiology.

We wish to enjoy the seasons and a change in elevation and plan to move sometime next fall when the NPHSC scholarship obligation will have been completed. The outdoor life is of special interest to us, whether skiing, hiking, camping, or just lounging under tall trees.

If you are aware of openings in your area please feel free to supply them with copies of our respective C.V.S., or to contact us directly with their addresses or phone numbers so that we may contact them ourselves. I am sure that your staff is busy and even overworked, but any assistance which you can lend us could supply two more members to your society. Mr. Byron H. Googins, the director of Public Relations for the Florida Medical Association supplied your address and also the inspiration to contact the society. Thanking you for your cooperation, we are.

Sincerely yours,
Cynthia L. Christoph, M.D.
James L. Greve, M.D.

November 16, 1989

Dear Editor:

Organized optometry has been promoting the idea that routine eye examinations can be done more cheaply by optometrists than by medical doctors. To advance these claims, a couple of studies have been distributed from a unit of the State College of Optometry, State University of New York.

The claimed cost savings overlook the differences between an optometric examination and a complete medical eye examination, as well as the considerable savings that result from correct initial diagnosis and prompt professional medical treatment.

Every physician recognizes that these claims of cost savings, involving eye care in this instance, ignore those areas frequently overlooked when any type of medical examination or treatment is proposed by non-medical health care workers.

Following is a letter to the editor of a California publication for insurance brokers that fell victim to the promotion, and published the claims. We all understand that the insurance industry is under intense pressure to control health insurance costs. I encourage other physicians to consider increased communication with the insurance leaders in their state to prevent a recurrence of this unfortunate incident.

Sincerely,
Bruce E. Spivey, MD
Executive Vice President
American Academy of Ophthalmology

November 16, 1989

Ms. Kate Kincaid, managing editor
California Broker
4111 West Olive
Burbank, CA 91505

Dear Ms. Kincaid:

An article in the September issue of the *California Broker* has come to my attention, in which it is claimed that money can be saved by having one's eyes examined by an optometrist, rather than an ophthalmologist.

The claim may in fact be true, but misses the point of a medical examination. The article is based on claims made by a couple of studies done by---you guessed it---optometrists.

Insurance brokers should be among the first to recognize that the purchase of an important service should be based on the qualifications of the provider, rather than solely on claims of cost savings. The prudent purchaser of insurance asks, "How well qualified is my broker, and what is really being provided for the price quoted?"

There is long-standing confusion about the difference between ophthalmologists and optometrists. The important difference is quite simple: ophthalmologists are medical doctors. Ophthalmologists have years of training that qualifies them to provide a complete medical eye examination, and the clinical experience to diagnose and treat all types of eye diseases and trauma.

The purchaser of health isurance should receive a complete medical eye examination from a medical doctor for the same reason that he or she should receive a complete physical examination from a medical doctor: no one else is as well qualified to provide the professional service. Delay in diagnosis and treatment of eye disease can result in increased health insurance costs. Prevention of blindness, on the other hand, is a savings beyond price.

Sincerely
Bruce E. Spivey, MD
Executive Vice President
American Academy of Ophthalmology

Regional Office Report

As we conclude our first month at the Regional Office, I welcome the opportunity to review our initial weeks in operation.

As many have commented, we hit the ground running. The Regional Office has many objectives to attain in the coming months, literally a wish list of activities. Yet the most crucial of them is the establishment of an effective communication link among the districts and the State Society Headquarters.

With this in mind, my first priority was to visit each of the districts, meet with the President and/or their staff and explain my role as Regional Coordinator. During these meetings, I gathered information on the district and its members, and discussed current problems confronting them. If any conclusion was to be drawn from these meetings, it is that each of the six central and western districts are extremely different, due in part to their access to information and resources, yet in many instances they are dealing with very similar issues and concerns.

One subject which has resulted in many inquiries from the districts is the new medical waste regulations which went into effect on 6 November 1989. As you may recall from recent correspondence (mailed to the membership the week of 4 September 1989), these guidelines establish the requirements for the storage, labeling, record-keeping and disposal of infectious or physically dangerous medical or biological waste.

In response to these new regulations, the Massachusetts Medical Society has entered into a joint agreement with Med-Waste Management and Solution Services Inc., a division of the Joseph Freedman Company, to offer Society members one stop, full service removal and disposal of infectious and hazardous waste. (The details of which were mailed to the membership on 5 October 1989). If you would like more information on the service, please contact the Regional Office at 1-800-522-3112.

On 25 October, the Regional Office hosted an open house for the officers of the six districts, as well as the leadership of the State Society Headquarters. The evening began with cocktails at the Northampton office and was followed by dinner at a nearby restaurant. Though I considered developing a set agenda, I decided to aim for an informal meeting. The kickoff was a wonderful opportunity for the officers of the central and western districts to discuss matters currently on their minds, and in many cases unique to this region of Massachusetts.

Looking towards the future, I shall strive to maintain this pace, getting out to the districts, meeting with the members, bringing you information, and listening to your opinions and suggestions. My goal, as I mentioned, is to be a communication link between our region and the State Medical Society. Please use the office as such, and contact me whenever you deem it necessary. ■

Kerin L. Milesky, Regional Coordinator
West Central Regional Office
Massachusetts Medical Society

COMMITMENT

TO THE COMMUNITY
A strong commitment to my client's financial welfare is really an outgrowth of a long-standing commitment to the community. Helping people achieve their goals has always been part of me, whether by serving on local boards or advising individuals on investment choices.

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TO EXCELLENCE
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Excerpts of MMS Executive Briefs

Highlights of Medicare Part B Reform

The 101st U.S. Congress used its Omnibus Budget Reconciliation Act of 1989 to make broad changes in federal health programs including some with major implications for physicians.

Highlights of selected major provisions include:

- FEE SCHEDULE CHANGES
  Beginning 1 January 1992, and phased-in over five years, Medicare payments to physicians will be made according to a fee schedule to be developed using a Resource Based Relative Value Scale (RBRVS). Relative values will be based on a combination of three components—work (time, intensity), practice expenses and malpractice expenses. The latter two will be adjusted for geographical variations.
- VOLUME PERFORMANCE STANDARDS
  Beginning with fiscal year 1990 (1 October 1988-30 September 1990), Volume Performance Standards (VPS) will be used to reduce the rate of increase in Medicare Part B physician expenditures that would be expected based on growth in physician fees, enrollees, and volume intensity of services, and on changes in laws or regulations. The VPS's are: FY90,—0.5%, FY91—%; FY92—1.5%; thereafter, 2% annually.
- SELF REFERRALS
  Effective 1 January 1992, physician referrals of Medicare patients to clinical laboratories in which the referring physician (or an immediate family member) has a financial relationship will be *prohibited*, with certain exceptions.
- MALPRACTICE CLAIMS
  Mandates a GAO study, for completion no later than 1 April 1991, to examine alternative resolution procedures for malpractice claims under Medicare, to include "review of the feasibility of establishing procedures that involve no-fault payment or that involve mandatory arbitration."
- PHYSICIAN SUBMISSION OF CLAIMS
  Beginning 1 September 1990. physicians (as well as other suppliers) will be required to submit all Medicare claims, both assigned and unassigned, on a standard claim form within one year of providing a service, with sanctions provided for failing to do so.
- BONUS FOR UNDERSERVED AREAS
  Beginning 1 January 1991, provides a bonus of 10% on Medicare fees paid to physicians practicing in health manpower shortage areas.
- OUTCOMES RESEARCH AND PRACTICE GUIDELINES
  Effective as of passage of the act, establishes a new Agency for Health Care Policy and Research that will include major programs of research on outcomes of health care services and for development of clinical practice guidelines and of standards quality of health care.

MMS Looking into Credentialing Service

A feasibility study to determine if the MMS should create a *central credentialing* service for physicians is currently underway and scheduled for a mid-January completion date. The Society is exploring creation of the service with the cooperation of the Massachusetts Hospital Association, the Massachusetts Association of Medical Staff Services, and the Massachusetts Association of HMO's. In examining the rapidly spreading concept of central credentialing, the MMS seeks to safeguard information on physicians, while streamlining the credentialing process to ensure its cost-effectiveness and efficiency for physicians and health-care facilities. Under the service, the Society would assemble, update, and disseminate physician credentialing information to health-care facilities (the service would not replace the health-care facility's own credentialing committee or its functions). A pilot demonstration/development project is being considered for the Worcester area, following completion of the feasibility study. For more information about the program, contact the Department of Health Care Systems and Policy Analysis at MMS headquarters.

Legislative Breakfast Held

More than thirty-five physicians from the Franklin district attended a *legislative breakfast* on Friday, November 10 to hear first-hand information on the state's budget crisis and physician issues. The meeting was moderated by Franklin District President *Jane Winchester, M.D.*, and *William Callahan, M.D.*, chairman of the MMS Committee on Legislation. Senator John Olver (D-Amherst) and an aide to Representative Carmen Buell (D-Greenfield) attended the breakfast. Discussion also centered on the MMS 1990 legislative agenda. Two additional legislative breakfasts are scheduled for early December in the Worcester (December 1) and Hampshire (December 8) districts. District medical societies are encouraged to sponsor legislative breakfasts in their areas and to become more involved in the legislative process. The Department of Government Relations and the West Central Regional office (for western districts) can help coordinate these and other political activities. ■

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The H.D.M.S. and the Hippocrat are seeking a member to join the Editorial Board and assume the responsibility for gathering the articles and overseeing the publication of each issue, beginning with the May-June Issue.

Those interested should contact:

Dr. Nancy Weiss

Dr. Terry Ryan

or Mrs. Carol Nystrom

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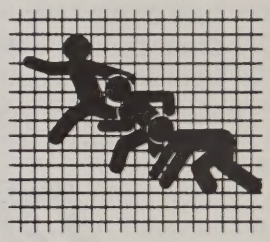

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Baystate Medical Center
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Springfield, MA 01199

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PREMED:	Springfield College, Massachusetts 1979-1985
MEDICAL:	University of Health Sciences College of Osteopathic Medicine 1985-5/89
INTERNSHIP:	Baystate Medical Center 7/89-Present
RESIDENT:	

Evan B. Gold, M.D.
299 Carew Street Suite 201
Springfield, MA 01104

BORN:	November 6, 1958
PREMED:	State Univ. of New York at Albany 1976-1980
MEDICAL:	Univ. of Miami School of Medicine 1980-1984
INTERNSHIP:	Mt. Sinai Medical Center, Florida 1985-1986
RESIDENCY:	Jackson Memorial Hospital, Florida 1984-1985, Boston University Associated Hospital 1986-6/89
SPECIALTY:	Ophthalmology

David L. Marinelli, M.D.
Baystate Medical Hospital
759 Chestnut Street
Springfield, MA 01199

BORN:	December 26, 1955
PREMED:	Yale University 1973-1978
MEDICAL:	University of Connecticut School of Medicine 1978-1981
INTERNSHIP:	St. Mary's Hospital, Connecticut 1982-1983
RESIDENCY:	Hospital of University of Pennsylvania 1983-1986
FELLOWSHIP:	Hospital of University of Pennsylvania 1987-1988
SPECIALTY:	Radiology

Thomas J. Moran, M.D.
299 Carew Street Suite 215
Springfield, MA 01104

BORN:	June 2, 1959
PREMED:	Tufts University 1977-1981
MEDICAL:	Tufts University School of Medicine 1981-1985
INTERNSHIP:	Baystate Medical Center 1985-1986
RESIDENCY:	Baystate Medical Center 1986-7/89
SPECIALTY:	Obstetrics/Gynecology

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Holyoke Hospital
575 Beech Street
Holyoke, MA 01040

BORN: January 18, 1956
PREMED: Massachusetts Institute of Technology 1973-1977
MEDICAL: University of Connecticut School of Medicine 1977-1981
INTERNSHIP: Hartford Hospital 1981-1982
RESIDENCY: University of Connecticut School of Medicine 1982-1985
FELLOWSHIP: Yale University School of Medicine 1985-1987
SPECIALTY: Psychiatry

Donna Prohazka, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: June 23, 1957
PREMED: Cornell University School of Arts & Science 1978-1980
Union College, New York 1975-1977
MEDICAL: Dartmouth Medical School, New Hampshire 1984-1988
INTERNSHIP: Baystate Medical Center 1988-6/89
RESIDENCY: Baystate Medical Center 7/89-Present
SPECIALTY: Radiology

Bhavesh L. Shah, M.D.
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BORN: August 9, 1946
MEDICAL: University of Bombay, LTM Medical College, India 1964-1969
INTERNSHIP: Niagra Falls Memorial Medical Center 1971-1972
RESIDENCY: Hartford Hospital, Connecticut 1972-1973
FELLOWSHIP: University of Connecticut School of Medicine 1975-1977
SPECIALTY: Pediatrics and Neonatal/Perinatal Medicine

Michael R. Verrilli
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Springfield, MA 01103

BORN: December 20, 1952
PREMED: Franklin & Marshall College, PA 1970-1974
MEDICAL: Michigan State University 1978-1982
INTERNSHIP: Botsford General, Michigan 1982-1983
RESIDENCY: Cleveland Clinic, Ohio 1983-1986
FELLOWSHIP: Hartford Hospital, Connecticut 1986-1988
SPECIALITY: Internal Medicine/Infectious Disease

Edward M. Dean, M.D.
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BORN: December 1, 1957
PREMED: Northeastern University 1977-1981
MEDICAL: Albany Medical College, New York 1983-1987
INTERNSHIP: Baystate Medical Center 1987-1988
RESIDENCY: Baystate Medical Center 1988-Present
SPECIALITY: Internal Medicine
RESIDENT

Brian P. Murphy, M.D.
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BORN: October 14, 1957
PREMED: Boston College 1975-1979
MEDICAL: Bowman Gray School of Medicine, Wake Forest 1983-1987
INTERNSHIP: North Carolina Baptist Hospital 1987-1988
RESIDENCY: Baystate Medical Center 1988-Present
SPECIALTY: Radiology
RESIDENT

John P. O'Grady, M.D.
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BORN: October 22, 1945
PREMED: Hartwell College, California 1963-1964
Stanford University, California 1964-1968
MEDICAL: Yale University School of Medicine 1968-1972
INTERNSHIP: Medical College of Virginia 1972-1973
RESIDENCY: Yale New Haven Hospital 1973-1976
FELLOWSHIP: King Drew Medical Center, Califonia 1976-1978
SPECIALTY: Obstetrics/Gynecology and Fetal/Maternal Medicine

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